Building Partnerships to Rebalance Long Term Services and Supports in Maryland

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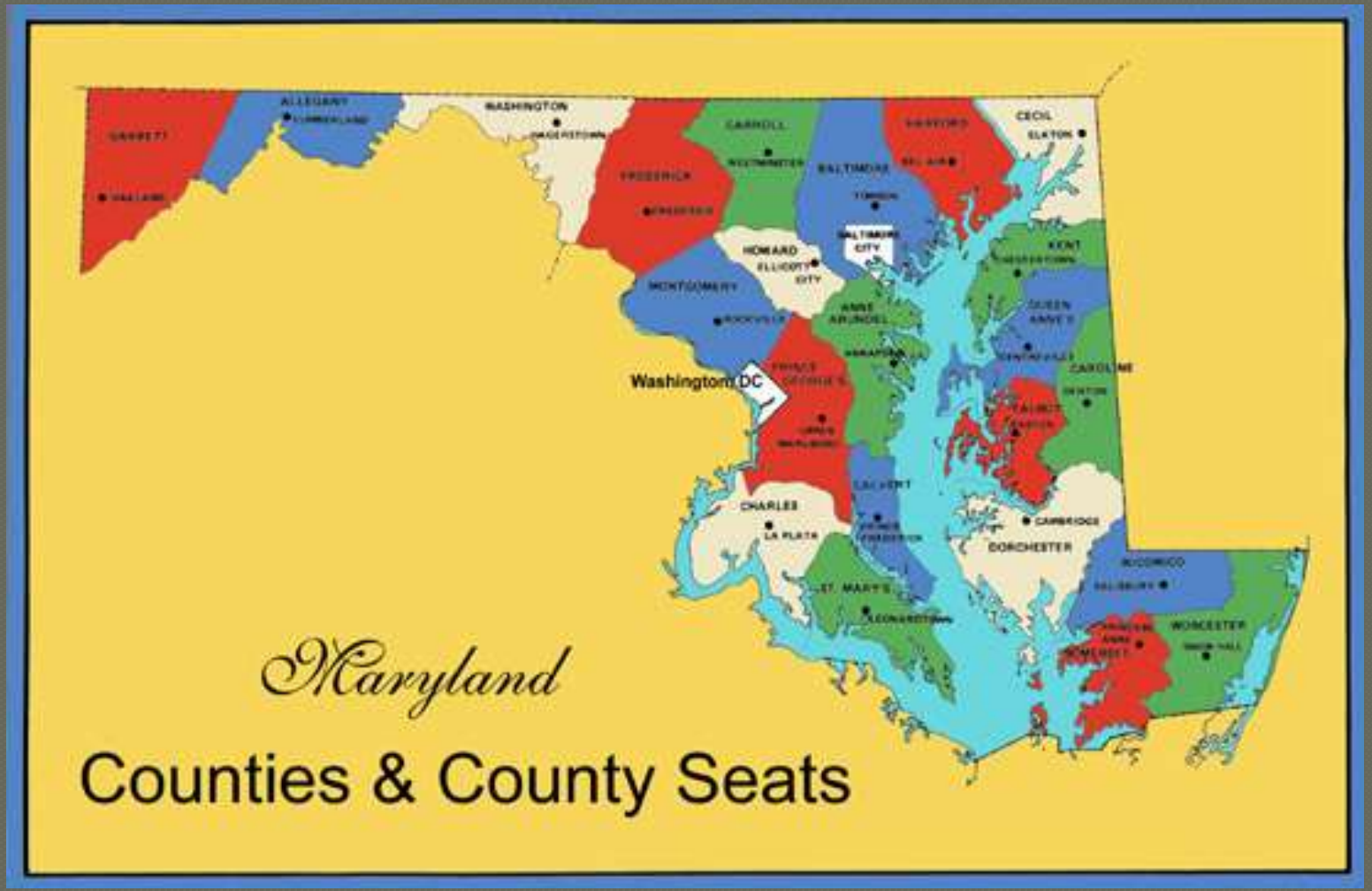
Rebalancing Goals

- Improving access to home and community-based services (HCBS).
  - Eliminate barriers to receiving HCBS.
  - Coordinating services and increase collaboration between agencies.
  - Enhance person-centered focus.
- Shift focus from institutional settings to HCBS.
  - Shift spending.
  - Increase self-direction options.
  - Take advantage of opportunities presented through the Affordable Care Act.

Maryland Overview



- http://msa.maryland.gov/msa/mdmanual/36loc/html/02maps/seatc.html

State- and Local-Level Challenges

- Numerous State programs are administered at the local level
- From the State perspective, this can make it difficult to oversee programs and ensure consistency, quality, and provider choice for all Maryland residents
- From the local perspective, it causes problems when changes occur without adequate funding or time for planning and changes to budgets

Maryland's HCBS Service System

- Department of Health and Mental Hygiene (DHMH)
  - State Medicaid Agency
  - Nine1915c waivers
    - Administered across various state agencies and administrations
  - Medical Assistance Personal Care
  - PACE
  - Oversight of No Wrong Door efforts
- Department of Aging (MDoA)
  - No Wrong Door-Operating State Agency
  - Senior Care
  - Veteran-Directed Home and Community Based Services
  - Community Living Program and Options Counseling
- Department of Disabilities (MDOD)
  - Attendant Care Program
- Department of Human Resources(DHR)
  - Medicaid eligibility determination
  - In-Home Aide Services
  - Project Home

Aging

- Technical Eligibility
- Waiver Services
- ACL/AoA Programs
- Personal Care

Health and Mental Hygiene (Medicaid Agency)

- Technical Eligibility
- Medical Eligibility
- Waiver Services
- Behavioral Health/TBI
- Developmental Disabilities
- Personal Care

Human Resources

- Financial Eligibility
- Office of Adult Services
- Adult Protective Services
- Personal Care

Disabilities

- Technology Assistance
- Constituent Services
- Public Accommodation in State Facilities
- Personal Care

Obstacles to Overcome

- Silos in the service system
- Unclear path to services
- Everyone wants to defend their territory
- Collaboration is fine as long as we still get to serve "our people"
- Lack of trust prevents real conversation about organizational strengths and weaknesses

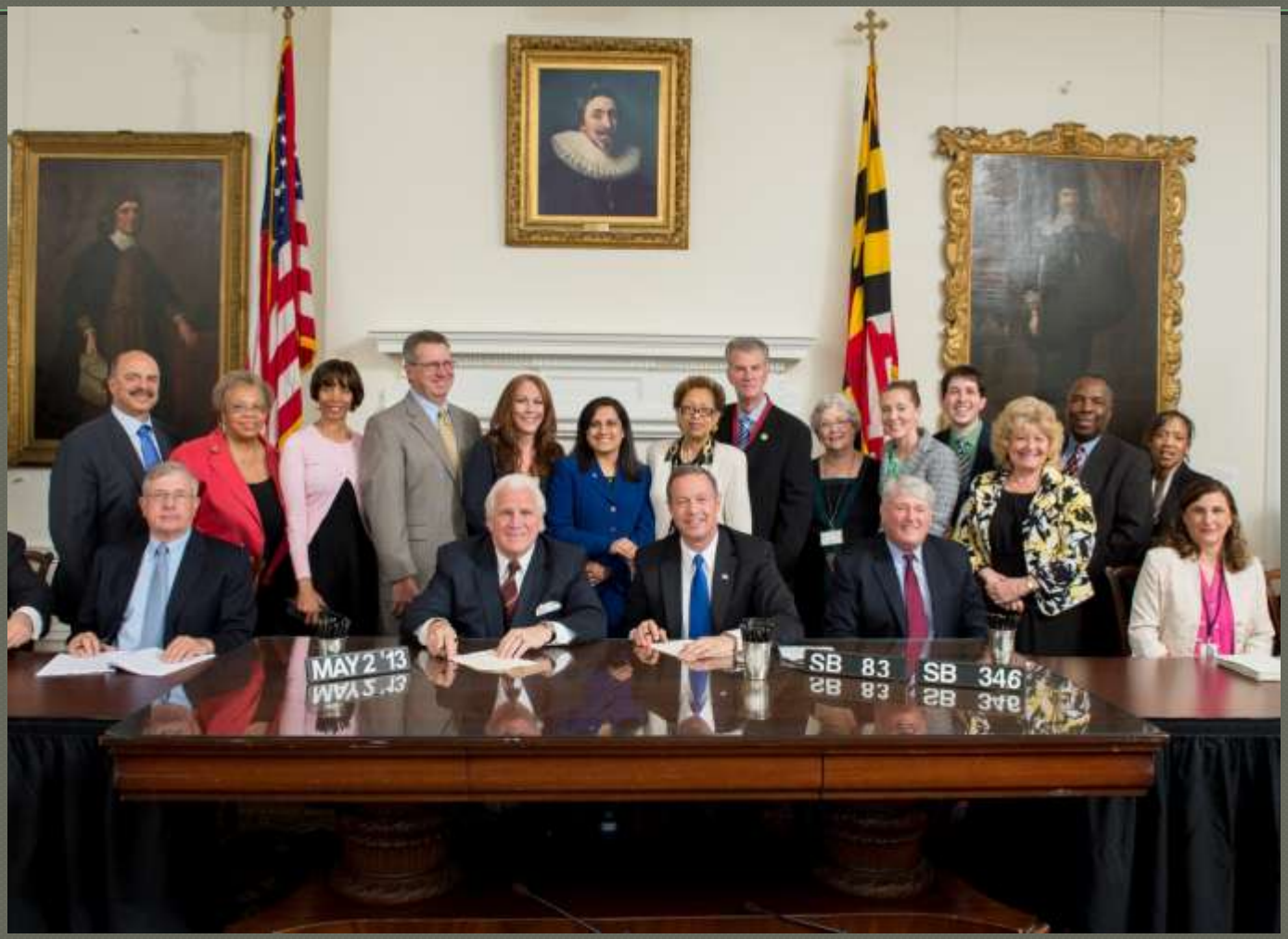
Understanding Each Other's Culture and History

- AAAs emerged as part of the Older Americans Act, seen as protective of a vulnerable population
- CILs emerged as the voice of people with disabilities that wanted the same rights to learn, work and enjoy life as individuals without disabilities.
- Disability advocates more distrustful of ADRCs efforts, they felt like the little "d" in AdRC, didn't want to be swallowed up by the larger network.
- Aging advocates not always enthused by advocacy efforts coming from CIL perspective, more focused on "health and safety" preventing people from the ability to make a poor choice.

History of ADRC and Rebalancing

- 2003 first grants: Maryland was one of twelve states with two local sites, one led by the Health Department the other by a AAA
- 2008-Money Follows the Person Program Operational
- 2010-Searchable MAP website went live: marylandaccesspoint.info, Maryland awarded ADRC grant to integrate peer activities into MAP sites, best practices manual
- 2011-AoA Options Counseling pilot, MFP revised to provide nursing facility options counseling through AAA/CIL partnership
- 2012-MAP Program statewide with 20 sites, Balancing Incentive Program award of $106 million (CMS), Expanded Options Counseling Grant (ACL)
- 2013-Senate Bill 83 codified ADRC in State statute

Governor Martin O'Malley signs Senate Bill 83-Partners Present



Maryland Access Point: No Wrong Door

- MAP-a visible, trusted place to seek information about and access to LTSS
- Shared information system, no need to repeat your story
- Level one screen that indicates risk of institutionalization, help prioritize based on need
- Able to counsel the individual on available options and resources in a crisis or for future planning

By marketing and strengthening the MAP single-entry point system, we can triage people into programs more effectively

MAP Staff begins Options Counseling
Person asks a question or tells their story.

Answer brief questions

Develop MAP Support Plan

Make initial referrals (e.g., mental health, VA, traumatic brain injury)

Trigger responses: The person needs personal care, has stated he/she has functional deficiencies, or may move because of physical needs.

MAP Staff completes the interRAI-MD Screen (should take about 15 minutes)

After the screen is completed, the person is ranked in order of need and date screened

When a program is able to provide a service, the person will receive an in-depth interRAI-Home Care assessment

MAP staff has access to LTSSMaryland to follow the process and provide updates to the person if they call back.

Connecting Information Systems

- LTSSMaryland-Integrated tracking system that houses:
  - Demographic information
  - Functional assessment tool
  - Program information
  - In Home-Supports Assurance System (ISAS) (attendant care voice recognition system)
- Future functionality to include:
  - Nurse monitoring tool
  - Reportable Events
  - Self-directed, flexible plan of service
  - Consumer portal

MAP Program Involvement

- Aging and Disability Resource Center Program
- Veteran-Directed HCBS Program
- Care Transitions Programs
- Community Living Program
- Options Counseling Development
- Money Follows the Person
- Balancing Incentive Program
- Community First Choice Option

MFP MAP Grants

- Provides funding for the partnership, at least 15% of funding must go to disability partner
- Co-location is strongly recommended
- Cross training
- Consultation in areas of expertise, such as assistive technology
- Participation in State-led work groups

Current State of MAP

- All 20 MAP sites are up and running, statewide coverage
- MAPs provide MFP options counseling to nursing facility residents
- MAPs are the backbone of Maryland's No Wrong Door efforts as part of BIP
- Working towards a statewide 1-800 number that will connect to the local MAP site, planned for 2014
- MAPs will conduct the level one screen as the entrance to LTSS for people seeking
  - Waiver
  - Community First Choice and MAPC
  - State-funded programs
- Current work groups related to business planning for sustainability (exploring FFP), developing MOU templates, referral protocols, standardized intake process, training requirements, and options counseling standards.

Lessons Learned

- Communication is key to partnerships
  - Sitting at the same table
  - Regular stakeholder feedback and input
  - Shared decision making
- Reorganization is not always needed
- Pooling of resources
- Tolerance for conflict
- Commitment at all levels-champions
- Perseverance
- Shared vision and coordination of plans
- Formalized partnerships

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